OFFICE OF THE CHILD ADVOCATE
REPORT

FAMILIES UNDER THE SUPERVISION OF NEW JERSEY'S DIVISION OF YOUTH AND FAMILY SERVICES
An Examination of Case Practice Performance and Recommendations for Reform

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Table of Contents

Section I – INTRODUCTION

The Office of the Child Advocate (OCA) embarked upon this study to examine how DYFS promotes child safety and serves families under its supervision. This report is the result of the largest document review ever undertaken by the OCA, which was made possible through our collaboration with Action for Child Protection, Legal Services of New Jersey and the Association for Children of New Jersey. This study encompassed thousands of records involving 269 children within 124 families who were under the supervision of the Division of Youth and Family Services (DYFS) for up to 18 months between January 2004 and June 2005. Because these families came under DYFS supervision when the agency believed their children were at risk of harm, this study first evaluated DYFS' process for assessing families and then examined DYFS' implementation of service plans designed to strengthen families, keep children safe and prevent removal of children to out of home placement. This review focused on DYFS' case practice and policies at its key decision points:

(1) Determination of risk to the child(ren), need for DYFS supervision of the family and minimum visitation schedule between DYFS case manager and family;
(2) Identification of family's problems and service needs;
(3) Determination of family and DYFS' progress in meeting goals of the service plan;
(4) Confirmation of child(ren)'s ongoing safety; and
(5) Response to any new allegations of abuse/neglect and/or referrals regarding the family

Although New Jersey is now 18 months into its implementation of a comprehensive child welfare reform plan, the data reviewed for this study offers a snapshot of agency practices much earlier in the process of change and reform. The records reviewed in this study covered a period up to 6 months prior to the implementation of that plan, and then for the first 12 months of the reform process, ending in June 2005. All of the cases within this sample were opened for supervision between January and March 2004, which was one of the most tumultuous periods in the history of New Jersey's child welfare system, and much has changed since that time. The findings within this report are not a verdict on the overall reform, or necessarily a reflection of current practices. Instead, this report offers comprehensive baseline data from a period early in the reform effort, against which future agency performance can be measured to gauge progress.

Though for many it may go without saying, government can never love a child the way a family must. For this reason and many others, whenever government has the choice to safely stabilize a child within a family or remove that child to state care, the better course in general is to maintain families, when safe, and support the natural bonds of affection and commitment that play so large a role in child development. The general trends in the findings of this study suggest that the State did not fully avail itself of opportunities to promote healthy, stable families. This is not to say that accomplishing those objectives with these families would have been easy. The unwillingness or unavailability of family members to receive services through DYFS loomed as a significant barrier among many of the cases studied for this review. But too many families

within this study appeared adrift, without assistance and supervision, not the better or the stronger for their having come into contact with DYFS. The results of this study, once again, accentuate the urgency of child welfare reform for the children and families of New Jersey.

This review unearthed considerable evidence that DYFS case practice, during the review period, fell short of agency policy. In the majority of cases, case managers did not engage caregivers and children in the process of identifying their problems or planning to resolve them. Every family, no matter how dysfunctional, has strengths – extended family or other informal resources, a unique blend of attributes, characteristics and values – to build on. In almost 40 percent of the cases in this review, DYFS cases managers did not assess the overall strengths of the family unit. In 30 percent of the cases, the case manager did not identify the strengths of the caregiver; and among those, nearly one in five was determined without input from the caregiver. The data suggests that case managers lack the time, and/or the skills, to identify what the family does well in order to establish a foundation for their work with them. The results of this study raise questions about the role of government in supporting families and about what it meant, if anything, to be a family under DYFS supervision between January 2004 and June 2005.

Major Findings

In many cases there was insufficient documentary evidence of deliberate joint decision-making between DYFS and the family, with the guidance and support of agency supervision. Decisions about children and families were often made by default through the passage of time. Following are the critical findings of this study:

- **Safety plans and case plans:** Of the 23 safety plans that were developed by DYFS within this study to keep children safe, the reviewers determined that 16 fully addressed and ameliorated the identified safety factors; seven did not. Although there were documented case plans in 79 percent of the cases reviewed, good planning by DYFS was only evidenced for 9.7 percent of families.

- **In no cases that lacked caregiver input was the case plan in complete accordance with the strengths of the family, caregiver, or child. However, in 16 cases where the caregiver participated, the case plan was deemed to be completely consistent with the strengths of the family, caregiver, or child, strongly suggesting family participation is essential to effective case planning and service implementation.**

- **Case managers rarely complied with the minimum visitation requirement established for the family.** Each of the cases in the study was open (including time in the intake phase) a minimum of 15 months. In 50.8 percent of the cases, less than six visits were made to the home after the initial referral, including one case where no visits were made. In 33.9 percent, less than eleven visits were made during the review period.

- **Supervisors provided minimal direction and oversight to case managers working directly with the family.** In only 29 percent of the cases reviewed did the quality of

supervisory oversight and direction show evidence of supervisory input into achieving the case goals and positive outcomes for children.

- **Of the 26 cases in which at least one of the children was removed from the home, the readers opined that the removal may have been avoided in three cases (11.5%) if certain services had been provided to the family. But in most of the cases – 23 out of 26 (88.5%) - the readers opined the removal could not have been avoided by DYFS through the provision of additional services at the time of the removal.** Timely delivery of appropriate services throughout the agency's intervention may have led to a different outcome. The services that were needed and not provided were substance abuse treatment, mental health treatment, housing services, family counseling, treatment for severe aggression or behavior problems, and educational services.

- **Twelve families (9.7%) had no DYFS case manager assigned for some period of time during supervision by the agency.**

- **Case managers frequently did not assess family strengths consistently and properly.** Strengths of the family, caregiver and/or child were consistently assessed in less than half of the cases and strengths were only properly assessed 22.6 percent of the time.

- **Service implementation was most commonly impeded by the family's resistance or unavailability and the case manager's failure to make referrals for services.** The two most common barriers found by the readers were the unwillingness or unavailability of the caregiver or family in 29 cases, and the failure of the case manager to make a referral for services in 21 cases. Strategies to overcome barriers to service implementation were not typically implemented; such strategies were implemented in only 13 (44.8%) of the cases where the family or caregiver refused services or was unavailable.

- **Services such as family counseling, mental health treatment, parenting skills education, and substance abuse treatment were often not provided when needed.** All needed services were offered and received in only 15 (12%) of the cases.

The recurring theme in the major findings is that case management and service delivery were poorly directed and often hinged upon shallow assessment of the child's and family's circumstances and dynamics. The OCA recommendations, fully presented at the end of the report, establish priorities to address the critical imperatives elevated in this report. The recommendations address supervision, case management and ensuring the provision of appropriate services. A critical element of each area of recommendation is providing the workforce with the necessary training, tools and support to secure children's safety and stabilize families. The child welfare system currently lacks a cogent case practice model that fully supports the reforms and principles articulated in the Child Welfare Reform Plan. Case managers and supervisors must be trained and supported in the implementation of a practice model that builds in system accountability to assure practice is consistent with developed standards.

Screening, Intake and Case Opening Processes

In July 2004, DYFS converted to a centralized model for screening referrals to the agency. The Statewide Central Registry (commonly referred to as the SCR) has replaced a previously decentralized system where referrals were screened locally during regular business hours and centrally at the Office of Child Abuse Control overnight, weekends, holidays and during cases of emergency. The system has experienced some start-up difficulties during implementation of the centralized screening model and conversion to a dual response system for responding to allegations. Problems have included, but are not limited to, confusion regarding coding and the designation of response times, delays in referrals reaching the assigned case manager for investigation and issues related to prioritization of cases for field response once assigned. Though screening and intake functions are not the foci of this audit, the case review necessarily gathered information related to those activities, since they are the foundation for all later intervention with the family.

A screener responds to each call and makes the determination to prepare the referral for a field response, provide information and referral or otherwise direct the caller. Allegations of child abuse or neglect are coded for child protective services investigation. Other allegations may be screened for a child welfare assessment. In each case, the field response time is designated by the screener. During the period under review, the options for initial response included immediate, 24 hours, 72 hours and 10 days time frames. The ongoing child welfare reform has revised the response times to immediate and 24 hours. The assigned investigator is expected to make a finding or statement of conclusion within 60 days.[1] At the conclusion of the intake phase the investigator, in consultation with a supervisor, makes a determination regarding the need to open the case to provide protective or child welfare services to the family.

The 124 cases selected for the study included 119 new cases and five cases that were re-opened (previously known to DYFS). There were 34 cases referred for child welfare assessment (families who would benefit from prevention services) and 90 referred for child protective services investigation (allegations of physical abuse, neglect, sexual abuse, and/or emotional abuse). There were 230 varied complaints received in the 124 cases reviewed. The primary complaints were neglect (41); parenting issues/concerns (41); physical abuse (35); parental substance abuse (32); and sexual abuse (11). Of the 124 cases, reviewers found the response time designated by the screener to be appropriate in 102 cases. Twelve cases had not been assigned response times and in 10 cases, reviewers deemed the response time to be inappropriate. Appendix B provides data collected regarding the screening function and information gathered about the cases during the screening phase.

As noted above, agency policy provides the intake investigator 60 days to investigate the allegations and/or assess the family in order to determine the need for ongoing service delivery. The decision regarding the need for continued intervention is a critical decision point. The decision to open a case should minimally hinge upon considerations of the findings of the initial allegations, the level of risk to the children in the family and available protective factors, an assessment of the community's ability to provide necessary services to the family and the

[1] DYFS Field Operations Casework Policy and Procedures Manual, Chapter II.R., Section 206.

likelihood that the family will avail itself of services on behalf of the children without further agency intervention. Case managers and supervisors did not subject many of the cases in this study to such deliberate and rational judgment or comprehensive assessment. The case opening decision was frequently made by default as cases lay dormant in the DYFS intake unit well beyond the 60-days permitted by policy. In fact, several cases lay dormant for months from the time the initial investigation was complete until a subsequent referral came into DYFS much later. This raises concerns regarding how intake workers were supported in prioritizing their work – balancing the need to respond to new referrals (for children who may be in imminent danger) with the obligation to respond to the needs of families who require ongoing services and supervision. Some families in this study were left with inadequate assessment of their needs and delayed service implementation. This raises questions about the quality of supervision and caseload monitoring that was provided to assure that cases moved, either for ongoing services or termination, in a well-thought out and timely manner.

Overview of Preventive Services

In order to work effectively with families under the supervision of the child welfare system, case managers require a continuum of prevention services, as well as services targeted to address identified family needs while building on their strengths. Child abuse and neglect prevention activities generally occur at three basic levels that reflect the audience targeted to receive the service. Prevention services are framed on three levels that reflect the magnitude of the child's or family's needs. The focus of Prevention through Family Support is to promote the acquisition of knowledge and skills that make a family more competent, thus strengthening family functioning. Primary prevention targets the general population and offers services and activities before any signs of undesired behaviors may be present; no screening occurs. Primary prevention also focuses on informing the public at large about issues concerning abuse and neglect, raising awareness among political leaders, and communicating the need for additional community resources. Activities that direct services to children and families who possess risk factors associated with child abuse or neglect are secondary prevention activities. Determining who is at risk is based on etiological studies of why maltreatment may occur. Secondary prevention efforts and services are also provided before child abuse or neglect occurs. Tertiary prevention is provided after maltreatment has occurred to reduce the impact of the maltreatment and avoid future abuse. Tertiary prevention is treatment, and is a critical objective of a child protection system.[2]

Studies have been conducted on both the effectiveness and cost benefit of prevention services; states, including New Jersey, have developed strategies for redirecting funds and efforts towards preventing abuse and neglect.[3] In 2002, the New Jersey Task Force on Child Abuse and Neglect

[2] Julie L. Gerberding and The National Center for Injury Prevention and Control, *Using Evidence-Based Parenting Programs to Advance CDC Efforts in Child Maltreatment Prevention* (2004).

[3] According to a study done by Prevent Child Abuse America in 2001, a year during which 905,000 children were victims of abuse or neglect, the total cost, including both direct and indirect costs, of child abuse and neglect is $94,076,882,529 annually. Direct costs, totaling $24,384,347,302, include hospitalization, treating chronic health problems related to abuse, mental health treatment, funding the child welfare system, providing law enforcement, and funding the judicial system. Indirect costs, totaling $69,692,535,227, include costs related to special education, mental health and healthcare, juvenile delinquency, lost productivity to society, and adult criminality. Prevent Child Abuse America, *Total Estimated Cost of Child Abuse and Neglect in the United States* (2001).

developed *New Jersey's Statewide Child Abuse and Neglect Prevention Plan*. Some initial steps under the Plan include the creation of the Division of Prevention and Community Partnerships, the creation and copywriting of the Standards for Prevention Programs and the White Paper on Home Visiting. A new plan for 2005-2008 is currently under development.

Section II. FINDINGS

Description of Case Demographics

This section provides descriptive information on the sample of cases reviewed in this study. This information includes the region from which the case originated and demographic information on the alleged victims and other children residing in the home, including gender, ethnicity and age. Appendix B provides additional information relating to the screening and initial investigation of the cases reviewed.

Description of DYFS Region

One hundred twenty-four cases were reviewed from 29 DYFS district offices, representing four regions (Central, Metropolitan, Northern and Southern).[4] The majority of the cases originated in the Metropolitan region (41.1%), followed by the Southern region (36.3%), the Northern region (17.8%) and the Central region (4.8%).

TABLE 1 – DYFS REGION

DYFS Region	Frequency	Percent
CENTRAL	6	4.8
METROPOLITAN	51	41.1
NORTHERN	22	17.8
SOUTHERN	45	36.3
Total	124	100.0

Description of Child Victims

There were 165 total children identified as child victims in the referral reports contained in the case records reviewed. Seventy-three percent of the reports alleged only one victim, 14 percent alleged two victims, and the remaining reports alleged more than two victims. Six reports did not identify a specific victim.[5] The following table presents these results.

[4]The Central Region is comprised of Mercer I, Mercer II, Ocean, Northern Monmouth, and Southern Monmouth; the Metropolitan Region includes Newark I, Newark II, Newark III, Newark IV, East Orange, Bloomfield, Perth Amboy, Edison, Union East, and Union West; the Northern Region encompasses Bayonne, Jersey City, North Hudson, Bergen, North Passaic, Central Passaic, Morris, Sussex, Warren, Hunterdon, and Somerset; the Southern Region is made up of Atlantic, Burlington, Camden North, Camden South, Camden Central, Camden East, Cape May, Gloucester, Cumberland, and Salem.

[5] Two of these cases were referred by the Court in order to obtain services for children in the juvenile delinquency system; one referral was an effort towards procuring services for a child being discharged from a residential treatment center; another was to obtain counseling for a family coping with sexual assault of a teenager; in one referral a birth mother requested assistance with her electric bill; lastly, no victim was identified in a referral alleging sexual assault (only the juvenile offender was identified). Each of these cases was coded at screening for a child protective services investigation; however the allegations would have been more appropriately coded as child welfare concerns since there is no alleged victim of child abuse or neglect.

TABLE 2 – NUMBER OF ALLEGED VICTIMS/REPORT

Number of Children Per Report	Frequency	Total Number of Child Victims	Percent
NO CHILDREN	6	0	4.9
ONE CHILD	91	91	73.4
TWO CHILDREN	18	36	14.5
THREE CHILDREN	3	9	2.4
FOUR CHILDREN	2	8	1.6
FIVE CHILDREN	3	15	2.4
SIX CHILDREN	1	6	.8
Total	124	165[6]	100.0

Description of Children Living in the Home

As previously stated, there were 165 children who were identified in the referral reports as being maltreated. However, in many cases there were other children in the home who were either not identified during screening or were not alleged to be victims of abuse or neglect. There was a total of 269 children in the cases sampled.

TABLE 3– NUMBER OF CHILDREN LIVING IN THE HOME

Number of Children Per Report	Frequency	Total Children in the Home	Percent
ONE CHILD	47	47	38.0
TWO CHILDREN	37	74	29.8
THREE CHILDREN	20	60	16.1
FOUR CHILDREN	13	52	10.5
FIVE CHILDREN	6	30	4.8
SIX CHILDREN	1	6	.8
Total	124	269	100.0

The age of children in the home ranged from less than 1 year (10.8%) to age 18 (0.4%). The ages of four of the children could not be determined from the record. One hundred-fifteen children, nearly 43 percent of the total sample, were six years old or younger. The gender of children was almost evenly split with 49.8 percent male and 48.3 percent female.

TABLE 4 – AGE OF CHILDREN IN THE HOME

Age of the Child	Frequency	Percent
<1 YEAR TO 6 YEARS	115	42.7
7 YEARS TO 12 YEARS	80	29.7
13 YEARS TO 18 YEARS	70	26.1
UNKNOWN	4	1.5
TOTAL	269	100.0

[6] Of the total 269 children in the sample 165 were alleged victims of child maltreatment. The remaining 104 children are either the siblings of the alleged victims or children referred for child welfare assessment and prevention services.

TABLE 5 – GENDER OF CHILDREN IN THE HOME

Gender of the Child	Frequency	Percent
MALE	134	49.8
FEMALE	130	48.3
UNKNOWN	5	1.9
Total	269	100.0

In 2003, the last year for which demographic data is currently available, the U.S. Census Bureau determined that the majority of children in New Jersey were Caucasian (58%).[7] African-American children represented 16 percent of the child population and Hispanic children accounted for 18 percent. However, the largest plurality of children in the sample was African-American (40.5%). Thirty percent of the children were Caucasian and twenty-one percent were Hispanic. This finding is consistent with other data documenting the disproportionate appearance of children of color within the child welfare system.

TABLE 6 – ETHNICITY OF CHILDREN IN THE HOME

Ethnicity of the Child	Frequency	Percent
AFRICAN-AMERICAN	108	40.1
CAUCASIAN	81	30.1
HISPANIC	57	21.2
ASIAN/PACIFIC ISLAND	1	.4
INTERRACIAL	6	2.2
OTHER & UNKNOWN	16	6.0
Total	269	100.0

Family Assessment, Engagement and Case Planning

This section examines the case practice relating to the comprehensive assessment of the family, engagement with the family, and case planning with the family. The total assessment of the family includes a determination of whether the children are safe in the family, an evaluation of the risk of future maltreatment, an assessment of the strengths and needs of each child, caregiver and the family as a unit, and integration of expert evaluations. Meaningful case planning requires a thorough understanding of all the family has to offer and should be guided by their self-determination as much as possible. The family often knows best what their struggles are and what resources they can bring to bear on their circumstances. The case manager engages the family in the development of the case plan and identifies goals that assure the safety of the children, maintains the integrity of the family unit (whenever possible) and moves the family toward stability and self-sufficiency.[8] The initial case plan, and the plan as it is revised to address the dynamic needs of the family, represents a key decision point in the case. It is

[7] 2003 Population of Children Ages 0-19, U.S. Bureau of the Census.

[8] SMART goals are those that are specific, measurable, achievable, realistic, and time-limited. Commonly accepted standards of child welfare practice support establishing goals that meet these criteria when working with children and families.

essential that the supervisor has input into the plan before the case manager meets to discuss it with the family, and reviews progress on the plan to monitor progress during regular supervisory conferences.

Engagement refers to the efforts the case manager makes to establish trust, rapport and a working relationship with each member of the family in order to finalize and attain the goals established in the case plan. The case planning process should build upon what is learned about the family through the process of engagement and comprehensive family assessment. The formal case plan is the document that identifies and captures the service needs of the family, establishes responsibility for implementation of services, and establishes the goals the parent(s) must meet in order to terminate the agency's supervision of the family.

Engagement, comprehensive assessment and case planning are essential elements of effective case management that is goal-oriented. When done well, these elements of case practice serve to strengthen the safety net for children, and buttress and maintain the integrity of the family unit. However, comprehensive assessment and engagement of the family in the planning process was, in general, suboptimal in the cases reviewed. Case managers did not appear to possess the time or skills required to thoroughly assess the totality of the family dynamics, presenting problems and their ability to respond appropriately to safety or risk factors for the children. There was generally a poor use of collateral resources to inform the assessment of the family. Assessments seldom went beyond the information provided about the family at the time of the referral; there was little exploration to determine what may have been percolating just beneath the surface. Similarly, case managers often seemed to lack knowledge of child development; the impact of mental health and substance abuse issues on the caregiver/family's ability to plan and follow through; the appropriate use of substance abuse evaluation, "random" urinalysis and treatment; and the basic tenets of relationship building and establishing rapport.

Safety Assessment

DYFS policy requires the case manager to assess child safety during the initial face-to-face contact with the family. The case manager must assess whether any child residing in the home is in imminent and/or impending danger of serious physical harm, which requires immediate protective intervention. In the cases reviewed, case managers complied with policy in 83 cases (67.0%). (Table 7) In the majority of the cases (63.7%), no safety factors were identified during the assessment (whether or not it took place at first contact). (Table 8) In most instances, the case manager assessed safety and took the necessary steps to implement and monitor the safety plan. A little less than one-third (29%) of the cases did not have a safety assessment and children were potentially left in harm's way.

TABLE 7 – SAFETY ASSESSED DURING INITIAL CONTACT

Safety Assessed	Frequency	Percent
NO	36	29.0
YES	83	67.0
UNKNOWN	5	4.0
Total	124	100.0

Table 8 reflects that at least one child in the family was determined to be unsafe in 25 of the cases. Where safety factors are identified, DYFS policy requires the development of a safety plan to remedy the safety threat if the child is to remain in the home.[9] In 24 of the 25 cases with identified safety threats, either a safety plan was developed to ensure the child's safety in the home (23 cases) or the child was removed from the home (1 case).

Of the 23 safety plans that were developed, the readers determined that 17 were implemented and monitored, and six were not. Sixteen safety plans fully addressed and ameliorated the identified safety factors; seven of the safety plans had marginal value but were not deemed sufficient to fully remedy the safety factor identified. In the remaining case where at least one safety threat was identified the case record lacked a safety plan for the child.[10]

TABLE 8 – SAFETY FACTORS IDENTIFIED

Safety Factors Identified	Frequency	Percent
NO	79	63.7
YES	25	20.2
NOT APPLICABLE (SAFETY NOT ASSESSED)	20	16.1
Total	124	100.0

TABLE 9 – SAFETY PLAN DEVELOPED

Safety Plan	Frequency	Percent
NO	80	64.5
YES	23	18.6
NOT APPLICABLE (SAFETY NOT ASSESSED)	20	16.1
CHILD REMOVED	1	.8
Total	124	100.0

TABLE 10 – IMPLEMENT & MONITOR SAFETY PLAN

Implementation & Monitoring	Frequency	Percent
NO	6	4.8
YES	17	13.7
N/A	101	81.5
Total	124	100.0

[9] DYFS Field Operations Casework Policy and Procedures Manual, Chapter II.A., Section 2004.

[10] During the course of the audit, the readers identified several (5) cases where, in their professional judgment informed by the limited information in the case record, there were immediate concerns regarding the safety of a child. In each instance these cases were brought to the attention of DYFS management for further review and to take action as they deemed appropriate. DYFS was appropriately responsive, and in one case litigation was initiated to protect the child.

TABLE 11 – PLAN ADDRESSED & AMELIORATED IDENTIFIED SAFETY FACTOR

Appropriate Safety Plan	Frequency	Percent
NO	7	5.6
YES	16	12.9
N/A	101	81.5
Total	124	100.0

DYFS is required to reassess safety whenever a new report of abuse or neglect is received while the family has an active case. Likewise, the investigator must develop a new safety plan whenever appropriate. The requirement to reassess safety at this critical juncture is to re-confirm the safety of the children in light of the new information about the family or the environment. Table 12 reflects that new allegations were received in 55 (44.4%) of the cases under review.[11] In 31 cases, or 56.4 percent of the cases receiving new allegations, safety was always assessed when new reports were received; in 15 cases, or 27.3 percent of the cases receiving new allegations, safety was never assessed upon receipt of a new report. This factor did not apply to 69 cases (55.7% of the total sample) because no new allegations were made during the period under review.

TABLE 12 – SAFETY ASSESSED WHEN NEW REPORTS RECEIVED

Safety Assessed	Frequency	Percent
NEVER	15	12.1
RARELY	1	.8
SOME OF THE TIME	5	4.0
MOST OF THE TIME	3	2.4
ALL OF THE TIME	31	25.0
NOT APPLICABLE	69	55.7
Total	124	100.0

Risk Assessment

The purpose of the risk assessment process is to identify whether a family has low, moderate, high, or very high probabilities of future child abuse or neglect. The tool currently used by DYFS is designed to obtain "an objective appraisal of the likelihood that a family will maltreat their children in the next 18 to 24 months."[12] It does not, however, predict recurrence; rather it assesses whether a family shares characteristics with a group of families who are more or less likely to have another incident of abuse or neglect if not provided prevention services or child protective services.

DHS has indicated that the case manager is only required by DYFS policy to complete the risk assessment form when safety factors have been identified. During the time period covered by

[11] Forty-two cases had one new report; seven cases had two new reports and six cases had between three and five new reports.
[12] DYFS Form 22-23 (New Jersey SDM Risk Assessment, Instructions).

the audit, the Child Welfare Plan commitments required DYFS to deploy tools to assess risk of children living in their own homes. Implementation was only partially deployed by the December 31, 2004 deadline.

Like safety assessment, risk assessment should be a continual dynamic case management process. Therefore, the review protocol for the audit permitted readers to give consideration to evidence of risk assessment other than on the form designated for this use. Other places bearing evidence of risk assessment included notes in the ongoing dictation in contact sheets, documented supervisory conferences, case plans and reassessment forms. Reviewers additionally examined whether risk was assessed at designated intervals, including each time the case manager came in contact with the child and family, when the case plan was renegotiated and when the MVR schedule was established.

Table 13 reflects that risk factors were identified by case managers in 61 of the cases reviewed and in 19 of the 25 cases where safety factors were identified. This is not meant to be a judgment of whether risk, as identified, had been assessed properly.

TABLE 13- SAFETY FACTORS & RISK FACTORS IDENTIFIED

		RISK FACTORS IDENTIFIED		
		NO	YES	Total
SAFETY FACTORS IDENTIFIED	NO	43	36	79
	YES	6	19	25
	N/A	14	6	20
Total		63	61	124

Assessment of Strengths and Needs

The DYFS Field Operations Casework Policy and Procedures Manual states:

> "The goal of DYFS intervention is to restore the family system to the point where the parents can assume full responsibility for the care of their children without governmental involvement. The process through which this goal is achieved begins with a determination that a service need exists, followed by an evaluation of the family's needs and strengths to determine which specific services may be utilized most productively."[13]

Proper assessment of the strengths and needs of the family as a unit, as well as each caregiver and child individually, is critical to effectively intervening in the least intrusive manner. As with risk assessment, the review protocol permitted the reader to acknowledge assessment activities that were documented in places other than the designated form. Tables 14 through 19 reveal that strengths and needs, across the board, were not consistently or properly assessed. Overall strengths were only properly assessed 22.6 percent of the time (Table 14). Strengths of the family, caregiver and/or child were consistently assessed in less than half of the cases (Tables 15,

[13] DYFS Field Operations Casework Policy and Procedures Manual, Chapter II.A., Section 303.

16 and 18). The caregiver was noted to have participated in the identification of his/her strengths in 36 of the 60 cases where caregiver's strengths were identified. The child was only instrumental in identifying his/her strengths in 15 of the 43 of cases where the needs of the child were identified.

TABLE 14 – STRENGTHS PROPERLY ASSESSED

Strengths Properly Assessed	Frequency	Percent
NO	48	38.7
YES	28	22.6
UNABLE TO DETERMINE	6	4.8
NOT APPLICABLE (STRENGTHS NOT ASSESSED)	42	33.9
Total	124	100.0

TABLE 15 – FAMILY STRENGTHS IDENTIFIED

Family Strengths Identified	Frequency	Percent
NO	47	37.9
YES	49	39.5
NOT APPLICABLE	28	22.6
Total	124	100.0

TABLE 16– CAREGIVER STRENGTHS IDENTIFIED

Caregiver Strengths Identified	Frequency	Percent
NO	38	30.6
YES	60	48.4
NOT APPLICABLE	26	21.0
Total	124	100.0

TABLE 17– CAREGIVER PARTICIPATION IN STRENGTHS IDENTIFICATION

Caregiver Participation	Frequency	Percent
NO	24	19.4
YES	36	29.0
NOT APPLICABLE	64	51.6
Total	124	100.0

TABLE 18 – CHILD STRENGTHS IDENTIFIED

Child Strengths Identified	Frequency	Percent
NO	54	43.5
YES	43	34.7
NOT APPLICABLE	27	21.8
Total	124	100.0

TABLE 19 – CHILD PARTICIPATION IN STRENGTHS IDENTIFICATION

Child Participation	Frequency	Percent
NO	17	13.7
YES	15	12.1
NOT APPPLICABLE (STRENGTHS NOT IDENTIFIED)	61	49.2
NOT APPLICABLE (DUE TO CHILD'S AGE OR DEVELOPMENTAL STAGE)	31	25.0
Total	124	100.0

Engagement Efforts

Based on a review of the complete case record, readers rated the case manager's practice performance related to engagement of the child(ren), primary caregiver and secondary caregiver. The level of engagement was quantified by the number of attempts that the case manager made to interrelate with each individual and ranged from no engagement efforts to good engagement efforts; while the quality of engagement efforts hinged on whether the numerous attempts included varied approaches that were age appropriate, culturally appropriate, and timely.

Engagement efforts with the child were not optimal in most instances, with only 12 cases (9.7%) reflecting good engagement efforts by the case manager. In almost one third of the cases (30.7%), the case worker had marginal engagement efforts with the child, meaning there was more than one attempt but those attempts were not age appropriate or not timely. In twenty-six percent (26%) of the cases, the efforts were fair (two or more attempts that were sometimes age appropriate and somewhat timely). In 4.8 percent of the cases no efforts were made to engage the child.

TABLE 20 – ENGAGEMENT WITH CHILD

Level of Engagement	Frequency	Percent
NO ENGAGEMENT EFFORTS	6	4.8
POOR ENGAGEMENT EFFORTS	18	14.5
MARGINAL ENGAGEMENT EFFORTS	38	30.7
FAIR ENGAGEMENT EFFORTS	33	26.6
GOOD ENGAGEMENT EFFORTS	12	9.7
NOT APPLICABLE	17	13.7
Total	124	100.0

Readers found a higher level of engagement between the case manager and the primary and secondary caregivers. In 36.3 percent, the efforts were marginal; in 30.7 percent they were fair; and in 16.1 percent the case manager made good efforts to engage the caregiver. In four cases (3.2%), no efforts were made or the caregiver was unavailable or refused services. In 69 cases, case managers made efforts to engage secondary caregivers. In 23 of those cases marginal efforts were made; in 20 cases the efforts were fair and in 10 cases the case manager made good engagement efforts.

TABLE 21 – ENGAGEMENT WITH PRIMARY CAREGIVER

Level of Engagement	Frequency	Percent
CAREGIVER UNAVAILABLE OR REFUSED SERVICES	2	1.6
NO ENGAGEMENT EFFORTS	2	1.6
POOR ENGAGEMENT EFFORTS	17	13.7
MARGINAL ENGAGEMENT EFFORTS	45	36.3
FAIR ENGAGEMENT EFFORTS	38	30.7
GOOD ENGAGEMENT EFFORTS	20	16.1
Total	124	100.0

TABLE 22-- ENGAGEMENT WITH SECONDARY CAREGIVER

Level of Engagement	Frequency	Percent
NO ENGAGEMENT EFFORTS	8	6.5
POOR ENGAGEMENT EFFORTS	16	12.9
MARGINAL ENGAGEMENT EFFORTS	23	18.5
FAIR ENGAGEMENT EFFORTS	20	16.1
GOOD ENGAGEMENT EFFORTS	10	8.1
NOT APPLICABLE	47	37.9
Total	124	100.0

Efficacy of Case Planning

A case plan, a written statement of DYFS' intervention on behalf of a child and the family, must be developed within 45 calendar days of receipt of a referral and re-negotiated at least every six months.[14] DYFS policy encourages the involvement of all concerned parties in the development of the case plan. The case plan should be based upon a thorough assessment of the strengths and needs of the family, establish appropriate expectations of the family and services to be provided. For the purposes of this study, the term "case plan" was liberally construed to include court orders and any other written documentation of a plan for the family.

Documentation of a case plan was found in 79 percent of the cases reviewed. Of the 98 case plans developed, 72 (73.5%) were developed within 45 days of the referral but only 21 (21.4%) were re-negotiated at least every six months. Thus, while case managers, in a majority of the cases, engaged in some form of case planning during the investigation phase of the case, this level of case planning was not sustained. Where case plans are not revisited, the family may not be able to make sufficient progress to address their needs because of inappropriate services that do not address the family's dynamic needs.

[14] DYFS Field Operations Casework Policy and Procedures Manual, Chapter II.A., Section 1001; DYFS Field Operations Casework Policy and Procedures Manual, Chapter II.C., Section 1606.

TABLE 23 – DOCUMENTATION OF CASE PLAN

Case Plan	Frequency	Percent
NO	26	21.0
YES	98	79.0
Total	124	100.0

TABLE 24 – CASE PLAN DEVELOPED WITHIN 45 DAYS

Case Plan Developed Within 45 Days	Frequency	Percent
NO	26	26.5
YES	72	73.5
Total	98	100.0

TABLE 25 – CASE PLAN DOCUMENTED EVERY 6 MONTHS

Case Plan Re-negotiated Every 6 Months	Frequency	Percent
NO	77	78.6
YES	21	21.4
Total	98	100.0

In writing a case plan the case manager states the problems, as identified by the parent and case manager, which caused DYFS to become involved with the family, states the services or actions needed to resolve the problems and achieve the case goal, identifies who will accomplish or provide the services and the anticipated time frame for providing each service.[15] Of the 98 case plans documented, only seven, or 7.2 percent were in complete compliance with DYFS policy. Almost as many, however, were in complete noncompliance (5.1%). Nearly thirty-seven percent had some parts in compliance, 28.6 percent of the case plans were mostly in compliance and 22.4 percent were mostly not in compliance.

TABLE 26 – CASE PLAN COMPLIANCE WITH DYFS POLICY

Level of Compliance	Frequency	Percent
NOT AT ALL IN COMPLIANCE	5	5.1
MOSTLY NOT IN COMPLIANCE	22	22.4
SOME PARTS IN COMPLIANCE, OTHERS NOT	36	36.7
MOSTLY IN COMPLIANCE	28	28.6
IN COMPLETE COMPLIANCE	7	7.2
Total	98	100.0

The study further showed that absent or misdirected case planning was evident even when the case plan itself had some level of compliance with DYFS policy. Although there were documented case plans in 79 percent of the cases reviewed, good planning was only evidenced in

[15] DYFS Field Operations Casework Policy and Procedures Manual, Chapter II.A., Section 1003.

9.7 percent.[16] Other cases received fair planning (16.9%), marginal planning (19.4%) or poor planning (25%).[17] More cases, however, received absent or misdirected planning (29%).[18]

TABLE 27 – PRACTICE PERFORMANCE: PLANNING FOR CHANGE

Level of Planning for Change	Frequency	Percent
ABSENT OR MISDIRECTED PLANNING	36	29.0
POOR PLANNING	31	25.0
MARGINAL PLANNING	24	19.4
FAIR PLANNING	21	16.9
GOOD PLANNING	12	9.7
Total	124	100.0

Parental Involvement in Case Planning

Case plans are to be developed cooperatively with the family so that family members can have input into the need for services. Therefore, the case manager must seek full participation from the family whenever possible. In 75 cases, there was some evidence in the record that that caregiver participated in developing the case plan. Participation in case plan development is most often indicated by signing the plan. However, as only 69 case plans were signed, it is clear that a signature, in and of itself, is not evidence of participation or lack thereof. To draw judgment regarding participation, the reviewers looked for documentation in the case record that the case plan was discussed with relevant family members or that the case plan reflected the family's request for specific services or supports.[19]

TABLE 28 -- CAREGIVER PARTICIPATION IN PLAN DEVELOPMENT

Caregiver Participation	**Frequency**	**Percent**
NO	23	18.5
YES	75	60.5
NOT APPLICABLE	26	21.0
Total	124	100.0

TABLE 29 – CASE PLAN SIGNED BY CAREGIVER

Case Plan Signed	**Frequency**	**Percent**
NO	22	17.7
YES	69	55.7
NOT APPLICABLE (COURT ORDER OR NO CASE PLAN)	33	26.6
Total	124	100.0

[16] Good planning was defined as that which is individualized and relevant to the family with full participation from the family.

[17] Fair planning meant that the process reflected some family involvement and had some individualization and relevance. Marginal planning is that which was not family-oriented but directed towards on the primary caregiver or the child. Poor planning was not engaging but rather driven by the worker and resulted in a routine case plan.

[18] No planning was done with the family.

[19] In cases where the case plan was a court order and, therefore, could not be signed, the reader assumed participation if the parent was present at the hearing.

As would be expected, the data supported the notion that caregiver participation with case development significantly impacts upon the case plan's consistency with the strengths and needs of the family. In no cases that lacked caregiver input was the case plan in complete accordance with the family, caregiver, or child strengths. However, in 16 cases where the caregiver participated, the case plan was deemed to be completely consistent with the strengths of the family, caregiver, or child.

TABLE 30 -- PLAN DEVELOPMENT: CAREGIVER PARTICIPATION & CONSISTENCY WITH FAMILY STRENGTHS

		Case Plan Consistent With Family Strengths					
		NO/LITTLE CONSISTENCY	SOME/MOSTLY CONSISTENT	COMPLETELY CONSISTENT	UNKNOWN	N/A	TOTAL
Caregiver Participated	NO	3	8	0	3	7	21
	YES	14	22	6	2	29	73
	N/A	0	2	1	0	27	30
Total		17	32	7	5	63	124

TABLE 31 -- PLAN DEVELOPMENT: CAREGIVER PARTICIPATION & CONSISTENCY WITH CAREGIVER STRENGTHS

		Case Plan Consistent With Caregiver Strengths					
		NO/LITTLE CONSISTENCY	SOME/ MOSTLY CONSISTENT	COMPLETELY CONSISTENT	UNKNOWN	N/A	TOTAL
Caregiver Participated	NO	3	8	0	3	7	21
	YES	11	23	6	2	31	73
	N/A	0	0	3	0	27	30
TOTAL		14	31	9	5	65	124

TABLE 32 -- PLAN DEVELOPMENT: CAREGIVER PARTICIPATION & CONSISTENCY WITH CHILD'S STRENGTHS

		Case Plan Consistent With Child's Strengths					
		NO/LITTLE CONSISTENCY	SOME/ MOSTLY CONSISTENT	COMPLETELY CONSISTENT	UNKNOWN	N/A	TOTAL
Caregiver Participated	NO	4	6	0	3	8	21
	YES	12	13	4	5	39	73
	N/A	0	0	0	0	30	30
TOTAL		16	19	4	8	77	124

In addition to signing the case plan, family members who participate in developing the case plan also receive a copy of the plan. Caregivers are to receive a copy of the plan even if they do not participate in its development or exercise their right not to sign it. By providing a copy of the fully executed plan to the family, the case manager reinforces the family's commitment to the plan, or minimally, the family has it as a reminder of the commitments made, and expectations of all parties.

TABLE 33 – CAREGIVER/FAMILY RECEIVED COPY OF PLAN

Caregiver/Family Received Case Plan	Frequency	Percent
NO	70	56.4
YES	28	22.6
NOT APPLICABLE	26	21.0
Total	124	100.0

Service Provision

Services are provided to families when (1) there is a substantiated allegation of child abuse or neglect or (2) the welfare of the child is endangered and the condition can be eliminated or ameliorated by DYFS making available specific services on behalf of the child in his/her own home.[20] Timely provision of appropriate services, those required to meaningfully address the identified needs of the family, is essential to achieving the goals set for the child and family. When services are inappropriate, delayed or denied, potential risk of harm to the children is exacerbated. DYFS has an affirmative responsibility to perform reasonable efforts to provide the services required to prevent out-of-home placement or to facilitate family reunification. Reasonable efforts include taking necessary action to overcome barriers to service delivery in order to assure adequate opportunity to rehabilitate the caregiver and enhance family stability and/or to promote reunification, ensuring permanency for the children.

Services Provided

Identification of needs and problems is a prerequisite to service provision; services should be relevant to the identified problems or needs. In the cases reviewed, the most frequently identified family-related problems were family/household relationship problems, concrete service needs and needs related to the family's social or community support system (Table 34). The most frequently identified caregiver-related needs were parenting skills deficits followed by substance abuse or addiction and emotional stability/mental health problems (Table 35). The most common child-related problems identified were educational achievement, behavioral control, and emotional stability/mental health (Table 36).

TABLE 34 – FAMILY RELATED PROBLEMS & NEEDS

Family Problems & Needs	Frequency
FAMILY/HOUSEHOLD RELATIONSHIPS	52
CONCRETE SERVICE NEEDS	24
SOCIAL OR COMMUNITY SUPPORT SYSTEM	22
HOUSING PROBLEMS	15
PARTNER ABUSE	14
CHILD CARE	11
CUSTODY/VISITATION	11
OTHER	10
COMMUNICATION SKILLS	9

[20] *N.J.A.C.* 10:133C-2.5.

TABLE 35 –CAREGIVER RELATED PROBLEMS & NEEDS

Caregiver Problems & Needs	Frequency
PARENTING SKILLS	37
SUBSTANCE ABUSE/ADDICTION	32
EMOTIONAL STABILITY/MENTAL HEALTH	25
FINANCIAL/RESOURCE MANAGEMENT	12
LIFE SKILLS	11
OTHER	10
PHYSICAL HEALTH	4
INCARCERATION	3
CAREGIVER PERCEPTION OF ABUSE AND NEGLECT HISTORY	2
DEVELOPMENTAL DISABILITIES	2

TABLE 36– CHILD RELATED PROBLEMS AND NEEDS

Child Problems & Needs	Frequency
EDUCATIONAL ACHIEVEMENT	23
BEHAVIORAL CONTROL	21
EMOTIONAL STABILITY/MENTAL HEALTH	20
COPING SKILLS	19
PHYSICAL HEALTH	19
DEVELOPMENTAL NEEDS	10
OTHER	6
SUBSTANCE ABUSE	4

Although problems and needs were identified in the majority of the cases in the sample, in only 14 cases (11.3%) were all needs matched to specific services. In 33 cases (26.6%) most needs were matched to suitable services and some needs were matched appropriately in twenty-one cases. In 36 cases (29.1%) no needs were specifically matched to services or most needs were not matched appropriately.

TABLE 37 -- SERVICES IDENTIFIED TO MATCH NEEDS

Services Matched to Needs	Frequency	Percent
NO NEEDS SPECIFICALLY MATCHED TO SPECIFIC SERVICES	22	17.8
MOST NEEDS NOT MATCHED APPROPRIATELY TO SERVICES	14	11.3
SOME NEEDS MATCHED APPROPRIATELY; OTHERS WERE NOT	21	16.9
MOST NEEDS MATCHED TO APPROPRIATE SERVICES	33	26.6
ALL NEEDS MATCHED TO APPROPRIATE SERVICES	14	11.3
N/A	20	16.1
Total	124	100.0

Services Needed but Not Provided

Based on the identified problems and needs, reviewers determined that some services that were needed were not provided. Of these, the most frequently identified services were family counseling, mental health treatment and parenting skills education, followed by substance abuse treatment and social support services. In only 15 cases (12%) were all needed services provided.

Meeting the predominant service needs for the family as a unit, and the children and caregivers individually, was consistently a challenge. Fifty-two of the 124 families (42%) were experiencing difficulties in their family/household relationships, suggesting a need for family counseling. Similarly, the most noted need for the children (23 cases) was for educational supports and caregivers needed parenting skills education in 37 cases. Table 40 indicates that these predominant needs were consistently unmet: 37 families were left without needed family counseling, 17 instances where needed educational services were not offered, and 31 families were left without necessary parenting skills education.

TABLE 38-- SERVICES NEEDED BUT NOT PROVIDED

Services	Frequency
FAMILY COUNSELING	37
MENTAL HEALTH TREATMENT	36
PARENTING SKILLS EDUCATION	31
SUBSTANCE ABUSE TREATMENT	23
SOCIAL SUPPORT SERVICES	22
OTHER	21
EDUCATIONAL SERVICES	17
TREATMENT FOR SEVERE AGGRESSION OR BEHAVIOR PROBLEMS	16
DAYCARE SERVICES	13
HOME-BASED SERVICES	12
HOUSING SERVICES	12
MEDICAL HEALTH	12
CONCRETE SERVICES	11
PARTNER ABUSE SERVICES	8
LIFE SKILLS TRANING	6
TRANSPORTATION SERVICES	5
FINANCIAL MANAGEMENT SKILLS COUNSELING	2
LEGAL OR ADVOCACY	2
ALL NEEDED SERVICES PROVIDED	15

Barriers to Service Provision

Reviewers identified 92 cases where at least one barrier to service provision existed. There were a variety of reasons why services were not provided to the child, caregiver, and/or family. In some cases multiple reasons were cited. The two most common barriers found by the reviewers were the unwillingness or unavailability of the caregiver or family in 29 cases, and the failure of the case manager to make a referral for services in 21 cases. Other barriers included inaccessibility (7 cases), language barriers (5 cases) and waiting lists (5 cases).

TABLE 39 -- BARRIERS TO SERVICE UTILIZATION

Barriers	Frequency
SERVICES NOT AVAILABLE	2
SERVICES NOT ACCESSIBLE	7
LANGUAGE BARRIER	5
WAITING LIST	5
SERVICE HOURS	3
FUNDING UNAVAILABLE	3
DYFS UNWILLING TO PAY	3
NO REFERRALS MADE	21
CAREGIVER OR FAMILY UNWILLING OR UNAVAILABLE	29
OTHER	14

When a barrier to service provision exists, the case manager must develop and implement strategies for overcoming the barrier so that the family may receive the needed service. While some of the barriers identified were systemic, others could have been overcome by providing funding for a particular service. For example, in one case reviewed, a mother who was attending a GED course and fulfilling her mandatory work requirement for public assistance was unable to also participate in parenting classes due to scheduling conflicts. Similarly, in another case, a stepfather could not participate with services because he was working during the day and studying for his GED in the evening. In a third case, the father refused to participate in any evaluations that could not be translated into his native language. The cases where families refused to participate in services are of particular concern. The records did not reflect any efforts of the case managers to overcome this barrier. Lack of documentation suggests that efforts were not made and implies the need for training and supervisory support to utilize strategies to effectively intervene with these families.

The DYFS Field Operations Casework Policy and Procedures Manual states:

> The Worker must, in most situations, make consistent and concerted efforts to engage a family with a service. He must encourage, assist, and advocate for the family to both access and use appropriate services. While it is not necessary to continue making efforts which are clearly futile, it is necessary to make repeated efforts to engage the client family in prevention/reunification activities, perhaps trying to engage the family by trying different approaches.[21]

Despite DYFS policy that requires varied approaches, case managers implemented strategies to overcome this barrier in only 13, or 44.8%, of the cases where the family or caregiver refused services or was unavailable. Further, the study found that in seven cases where this barrier existed, no services were provided at all.

[21] DYFS Field Operations Casework Policy and Procedures Manual, Chapter II.A., Section 1302.1.

TABLE 40 – FAMILY/ CAREGIVER UNWILLING OR UNAVAILABLE & STRATEGIES TO OVERCOME BARRIERS

		Strategies to Overcome Barriers				
		NO	YES	UNKNOWN	NOT APPLICABLE	Total
Family/Caregiver Unwilling Or Unavailable	NO	20	13	1	61	95
	YES	16	13	0	0	29
Total		36	26	1	61	124

TABLE 41– FAMILY OR CAREGIVER UNWILLING OR UNAVAILABLE & NO SERVICES PROVIDED

		No Services Provided		
		NO	YES	Total
Family/Caregiver Unwilling Or Unavailable	NO	60	35	95
	YES	22	7	29
Total		82	42	124

Efforts to Overcome Barriers to Prevent Placement

Both federal and state law mandate that state agencies make reasonable efforts to preserve families prior to placing a child in out-of-home care. DYFS policy defines "reasonable efforts" as "the provision of services to the family that are individually assessed to be relevant to the case goal, coordinated with other services, available and accessible and that have a realistic potential to meet the child's needs for [a] safe, secure, and permanent relationship with a family or another permanent arrangement."[22] "Recognizing the traumatic effect that removal can have on a child, decisions to remove a child from his/her home [are] made only when there is imminent danger to the child, or risk of injury or death if the child remains at home, and that danger or risk cannot be alleviated by any resources currently available to DYFS or the family."[23] In the cases reviewed, at least one child was removed for every 26 cases where the family had been under DYFS supervision (21%). Of those removals, all but one was deemed reasonable by the reviewers.

When determining whether the removal was reasonable, reviewers applied DYFS policy to the presenting circumstances at the time of removal. The reviewer's conclusion regarding services provided to prevent removal was based upon whether any service, provided at the time of removal, could have kept the child(ren) safe in the home. There is the distinct possibility that some removals may have been prevented had the family had the benefit of proper case management and service implementation throughout DYFS' involvement with the family. For example, in one case where the reviewer deemed the removal to have been appropriate, a mentally ill mother withheld the child from school and lived in an apartment with no electricity. The reviewer opined that no services could have obviated the placement because the mother was

[22] DYFS Field Operations Casework Policy and Procedures Manual, Chapter II.A., Section 1302.
[23] DYFS Field Operations Casework Policy and Procedures Manual, Chapter II.A., Section 1301; DYFS Field Operations Casework Policy and Procedures Manual, Chapter II.D., Section 201.

unlikely to have agreed to voluntary mental health treatment. The reviewer's agreement with DYFS' decisions regarding removal should not be deemed a concession that the family received good case practice and service implementation prior to removal, or that the child could not have been kept safe in his home had the case manager provided the same. In fact, the reviewer noted that mental health treatment and concrete services were needed but not provided earlier in the case. In addition, the reviewer determined that the case manager did not implement strategies to overcome the barriers to service implementation. In the fifteen months that the case was opened for services, the case manager only made 6 visits to the home (including contact during the initial investigation) despite having a monthly MVR schedule.

The case management of the 26 cases in which at least one of the children was removed from the home is of concern. There was little evidence of consistent supervisory oversight or meaningful direction to assure progress toward case goals. In nine of the cases, supervisory conferences were semi-annual or less; in five cases, there were no conferences documented at all. In only 15 of these cases did the quality of supervisory direction move the case towards goal attainment. Seven cases were designated as high risk, but only three of those contained documentation of increased conferencing in light of the elevated risk to the child. There was also evidence of high case manager turnover and unstable coverage for a significant number of these cases. The majority of these cases (17) had 3-4 different case managers during the review period and two had five or more different case managers assigned to the case. Three of the 26 cases were uncovered (without an assigned case manager) for a period of time: one case was uncovered for fifteen days, another for 65 days and the third for 270 days. In only five of the cases where a child was removed were all criteria for a complete mandatory visitation requirement (MVR) with the family met by case managers on a regular basis. In fact, the majority of these 26 placement cases received fewer than ten home visits during the 15 to 17 month review period.

In three of these 26 cases, the reviewers opined that the removal could have been avoided if certain services had been provided. The predominant services that were needed and not provided were substance abuse treatment, mental health treatment, housing services, family counseling, treatment for severe aggression or behavior problems, and educational services. The case synopsis following Table 43 captures the circumstances of one of these cases.

TABLE 42 -- CASES WHERE AT LEAST ONE CHILD MOVED TO OUT-OF-HOME PLACEMENT

At Least One Child Moved to Out-of-Home Placement	Frequency	Percent
NO	98	79.0
YES	26	21.0
Total	124	100.0

TABLE 43 -- REASONABLENESS OF REMOVAL

Reasonableness of Removal	Frequency	Percent
NO	1	3.8
YES	25	96.2
Total	26	100.0

In February 2004, DYFS determined that two-year-old Tavon[24] was physically abused by his babysitter. During the course of the DYFS investigation, Tavon and his three-year-old brother, Xavier, could not remain with their mother, Katrina, because she was homeless. Katrina signed the 15-day consent to placement[25] and the children were placed in relative care. Katrina assumed that the placement would be temporary while DYFS helped her to locate permanent housing. However, after the 15-day consent expired, she was asked to sign a six-month consent because she remained homeless. The children remained with their maternal aunt until June 2004 when she informed DYFS that she could no longer provide care for the children. Tavon and Xavier were placed in a foster home for 1 month and then into separate relative care placements. Meanwhile, Katrina secured employment, attended parenting skills classes and searched for housing. By December 2004, she had secured housing in a boarding home, but she was informed by her landlord that no children were permitted.

When the six-month consent expired, DYFS went to court and was granted custody, care, and supervision of Xavier and Tavon, based solely on Katrina's inability to secure adequate housing for them despite her efforts and requests for assistance through DYFS and welfare. Time and again, Katrina asked her case manager for assistance but only a bus pass, a list of 8 agencies to contact and a form letter to present to each was provided. As this was the extent of the assistance she was provided, Katrina made no progress towards securing appropriate accommodations. Katrina's frustration with DYFS began to grow as the months passed and her children were moved from the maternal aunt's home to a foster home and then to separate relative placements, in two different cities.

Not only was Katrina becoming overwhelmed by her situation and her need to locate suitable housing, but DYFS then began referring her to services that required less urgency, like parenting skills classes. Soon, the bus pass that DYFS provided to assist her getting to work, housing agencies, parenting classes, and visits with her sons expired. After the children were in placement for over a year, Katrina began to visit them less and less, and the sibling visits also became less frequent. In June 2005, Xavier's caregiver reported that he had begun to wet his bed and she would like counseling for him. Katrina still did not have housing, which remains her only barrier to reunification.

Decision-making

Supervisory Oversight

Each family has a case manager and supervisor assigned to their case. While the case manager is primarily responsible for daily case management activity, the supervisor must maintain familiarity with the case through conferencing with the assigned worker on a regular basis. The supervisor is required to conference each case at least once per month with the case manager; more often if required based on the complexity or elevated level of risk of the case, or the experience or proficiency of the case manager. This study found one case where supervisory conferences were held weekly. In half of the cases (50%), conferences were only documented as being held once or twice a year and in 21 percent of the cases reviewed, no supervisory conferences were noted or documented in the case record.

The frequency of the case conferencing is to be determined by the supervisor based on the circumstances of the case and the case manager's skill level and degree of experience. For cases deemed to be high risk, conferencing should be more frequent (weekly) until the safety threats and concomitant risks are controlled or reduced enough that the case no longer warrants the high risk designation. Of the 14 cases deemed to be high risk, only 5 had documentation in the case record of increased conferencing. As noted in Table 45, only one case received weekly conferences.

[24] Fictitious names are used in the case synopsis to shield the privacy of the family.

[25] DYFS is no longer utilizing the voluntary consent or informed consent to out-of-home placement. Current policy requires court approval for placements. DYFS Field Operations Casework Policy and Procedures Manual, Chapter II.A., Section 1800.

TABLE 44– FREQUENCY OF RECORDED SUPERVISORY CONFERENCES

Supervisory Conference	Frequency	Percent
WEEKLY	1	.8
MONTHLY	4	3.2
BIMONTHLY	4	3.2
QUARTERLY	27	21.8
SEMI ANNUAL OR LESS	62	50.0
NO CONFERENCE NOTED	26	21.0
Total	124	100.0

TABLE 45 -- CASE IDENTIFIED AS HIGH RISK

High Risk	Frequency	Percent
NO	110	88.7
YES	14	11.3
Total	124	100.0

TABLE 46-- DOCUMENTATION OF INCREASED CONFERENCING

Increased Conferencing	Frequency	Percent
NO	9	64.3
YES	5	35.7
Total	14	100.0

In addition to case conferencing, the supervisor is also responsible for re-assignment of on-going cases. Readers found that 12 cases (9.6%) had a period of time when no case manager was directly responsible for the case. The DYFS supervisor failed to comply with agency policy requiring re-assignment of cases within two business days in each of the 12 cases.[26] .In fact, the least amount of time any of the 12 identified cases went uncovered was 15 days and two cases were without an assigned case manager for at least a year.

TABLE 47 -- CASE UNCOVERED FOR ANY TIME

Case Uncovered	Frequency	Percent
NO	112	90.3
YES	12	9.7
Total	124	100.0

[26] DYFS Administrative Policy and Procedures Manual, Chapter I.F., Section 206.2.

TABLE 48 --LENGTH OF TIME CASES WERE UNCOVERED

Number of Days	Frequency	Percent
15	1	.8
41	1	.8
60	1	.8
65	1	.8
150	1	.8
244	1	.8
270	1	.8
301	1	.8
305	1	.8
365	1	.8
455	1	.8
UNKNOWN	1	.8
NOT APPLICABLE	112	90.4
Total	124	100.0

Each supervisor is responsible to accompany the case managers under their supervision on field visits (client contacts outside of the DYFS office). For new workers, DYFS policy requires a minimum of one field visit every three months. For experienced workers, the minimum requirement is once every six months.[27] In only seven cases reviewed (5.6%) did a supervisor accompany the case manager on a field visit. This lack of compliance with DYFS policy greatly interferes with a supervisor's ability to make ongoing assessments of the case manager's skills.

TABLE 49 -- SUPERVISOR ACCOMPANIED WORKER TO FIELD TO SEE FAMILY

Supervisor Accompanied Worker	Frequency	Percent
NO	117	94.4
YES	7	5.6
Total	124	100.0

Even when not accompanying the worker on his or her field visit, the supervisor is responsible for ensuring that the MVR is established for the family and is being met. In more than half of the cases reviewed (57.3%), no MVR schedule was documented in the case record.

TABLE 50 --WAS THERE A MINIMUM VISITATION REQUIREMENT (MVR) SCHEDULE IN THE RECORD

MVR Schedule	Frequency	Percent
NO	71	57.3
YES	53	42.7
Total	124	100.0

[27] An experienced worker is one who has worked for DYFS for a minimum of one year or who has equivalent experience in a child welfare/child protection setting. DYFS Administrative Policy and Procedures Manual, Chapter I.F., Section 210.

Although the majority of the MVR schedules were deemed appropriate based on the family circumstances and risk level, few case managers met the minimum standard.[28] Each of the cases in the study was open (including time in the intake phase) a minimum of 15 months. In 50.8 percent of the cases, less than six visits were made to the home after the initial referral, including one case where no visits were made. In 33.9 percent, less than eleven visits were made during the review period.

TABLE 51 -- MVR SCHEDULE COMMENSURATE WITH SAFETY/RISK FACTORS IDENTIFIED

MVR Schedule Appropriate	Frequency	Percent
NO	4	3.2
YES	49	39.5
NOT APPLICABLE	71	57.3
Total	124	100.0

TABLE 52 -- HOME VISITS MADE TO FAMILY AFTER INITIAL REFERRAL

Home Visits	Frequency	Percent
0	1	.8
1-5	62	50.0
6-10	42	33.9
11-15	11	8.9
16-20	6	4.8
25-30	1	.8
UNKNOWN	1	.8
Total	124	100.0

Documentation of Decision-Making

DYFS policy requires the case manager to record case activity on the contact sheets as contemporaneously as possible with the occurrence of the contact or event, but no later than 30 days thereafter.[29] In 62.9 percent of the cases reviewed, the case manager complied with DYFS policy. In cases where the requirement was not met, documentation was sometimes transcribed six months to a year after the date of the event or activity. In some cases, documentation was so scant that it was difficult to piece the story of the family together.

[28] In the absence of a documented MVR schedule, readers assumed a monthly requirement as the minimum standard.
[29] DYFS Field Operations Casework Policy and Procedures Manual, Chapter II.A., Section 809.

TABLE 53 -- DOCUMENTATION COMPLETED CONTEMPORANEOUSLY

Contemporaneous Documentation	Frequency	Percent
NO	38	30.6
YES	78	62.9
UNKNOWN	8	6.5
Total	124	100.0

The supervisor is to review the contact sheets every 30 days (at minimum) and initial and date the last entry on the contact sheet.[30] Supervisors in 89 cases (71.8%) signed required documentation to indicate they had provided supervisory oversight. However, in spite of evidence of supervisory oversight, case management activity was insufficiently focused and goal oriented. In only 29 percent did the quality of oversight and direction show evidence of input into achieving the case goals and positive outcomes for children.

TABLE 54 -- SUPERVISORY OVERSIGHT APPARENT BY DOCUMENTATION OF REQUIRED SIGNATURES

Supervisory Oversight	Frequency	Percent
NO	35	28.2
YES	89	71.8
Total	124	100.0

TABLE 55-- QUALITY OF SUPERVISORY DIRECTION SHOWS EVIDENCE OF INPUT FOR GOALS

Supervisory Input Into Achieving Goals	Frequency	Percent
NO	87	70.2
YES	36	29.0
UNKNOWN	1	.8
Total	124	100.0

Section III – EXEMPLARY CASE MANAGEMENT

As with all case review activity of the OCA, this audit was an exercise in learning about the system to determine how it may be enhanced to secure better outcomes for children and families. To that end, the OCA was also interested in identifying cases that presented good practice to identify what is being done well. At the inception of the review, reviewers were asked to make note of cases that they determined were handled particularly well. The two case vignettes that follow were elevated as models of excellent case practice.

The first case involved a 14 year-old child who was behaviorally out-of-control, running away and extremely self-injurious. The child was also a poly-substance abuser and had been suicidal. The father of the child is deaf and his speech was noted to be unintelligible, which added complexity to the nature of the intervention. The case manager was somewhat naïve regarding

[30] DYFS Administrative Policy and Procedures Manual, Chapter I.F., Section 207.

the expectations of the father to control the child and the child's ability to self-regulate. However, there is evidence of sustained effort over time to engage and support the family through consistent home visits and provision of appropriate services. The case manager, supported by good supervision, exerted extensive and intensive effort to obtain and see the child through successful inpatient treatment. The case manager was noted to use e-mail to communicate meaningfully with the father, and to establish contact with the child's mother, who is also deaf.

The second case involved a family of three children, one of whom is medically fragile. Although the initial referral on the family alleged neglect, the family presented with multiple problems and needed access to the full spectrum of services. The case manager assured the family had access to medical health services, parenting skills education, family counseling, home based services, day care services and other social support services. All needed services were provided to the family. The case manager was diligent to make excellent and thorough use of collateral contact information. The case manager fully engaged all family members in the development of plans for the family. The reviewer noted that the case manager did an excellent job of monitoring the child, providing services and communicating with physicians to assure the needs of the child were met.

Section IV. – CONCLUSION AND RECOMMENDATIONS

The most recent report of data from the National Child Abuse and Neglect Data System (NCANDS), indicates that "approximately 906,000 children were found to be victims of child abuse or neglect in calendar year 2003. Of this number, 60.9 percent suffered neglect, 18.9 percent were physically abused, 9.9 percent were sexually abused, 4.9 percent were emotionally or psychologically maltreated, and 2.3 were medically neglected. In addition, 16.9 percent of victims experienced "other" types of maltreatment such as "abandonment," "threats of harm to the child," and "congenital drug addiction."[31] For the same year in New Jersey, there were 8,236 substantiated cases of abuse and neglect. Of this number, 59 percent of the cases involved neglect, 27 percent involved physical abuse, 7.9 percent involved sexual abuse, 3.1 percent involved emotional or psychological maltreatment, and 2.5 involved multiple types of abuse.[32]

The New Jersey Division of Youth and Family Services has in excess of 60,000 children under its supervision at any given time. The overwhelming majority of these children remain in the care of their families of origin while receiving services to prevent maltreatment or ameliorate the trauma of experienced maltreatment. The federal Adoption and Safe Families Act (ASFA) requires that "safety [be] the paramount concern" in the provision of services to families[33]. Similarly, the state embraces the ASFA mandates to assure the safety of the children in its care or custody.[34] The New Jersey Child Placement Bill of Rights reaffirms that the safety of the child is paramount and establishes an expressed imperative for the State to provide reasonable efforts to prevent the placement of children outside of their home.[35] The timely provision of

[31] United States Department of Health and Human Services, Administration for Children and Families, Administration of Children, Youth, and Families, Children's Bureau, *Child Maltreatment* (2003).

[32] New Jersey Department of Human Services, Office of Children's Services, Division of Youth and Family Services, *Child Abuse and Neglect in New Jersey: Statistical Report for 2003* (2005).

services targeting the needs of children and families is essential to achieving and sustaining permanency for children, either in their families of origin or with an alternate caregiver.

The latest chapter of child welfare reform was brought into focus by the *Charlie and Nadine H.* lawsuit filed in August 1999, and again by the tragic death of Faheem Williams (January 2003) and the discovery of his abused and neglected surviving siblings while under the supervision of DYFS. Faheem's death was followed by the deaths of several other children known to DYFS throughout 2003. In July 2004, with the settlement of the lawsuit, the Department of Human Services, began a major reform effort that promised to change the way that the state child welfare system serves children and families. Among other things, the reform plan mandates a larger and better trained DYFS casework staff with smaller, manageable caseloads and a new case practice model that established a statewide central registry to accept reports of child abuse and neglect; trained forensic investigators to assess new allegations of child abuse and neglect; permanency workers to provide ongoing services to at-risk families; and a one worker-one family case management approach.

Recommendations

Whereas the OCA's reviews of child fatality cases provides a view of the child welfare landscape through a lens clouded by tragedy, this audit provides a more balanced view of case practice through a different part of the prism. The cases reviewed in this audit were drawn from a period of time early in the reform process. As such, the findings do not necessarily reflect the current condition of the system or case practice. This audit provides early baseline data and suggests areas for stricter scrutiny as the reform process continues to move forward. The OCA offers the following discrete recommendations as areas to prioritize to address the most pressing findings.

Supervision

This audit revealed the need to greatly strengthen the practices of DYFS supervisors. There was evidence of intermittent good supervisory direction and oversight which implies that many supervisors understood what is required, but somehow, they were impeded from consistently practicing at those standards. In most cases, supervisors provided minimal direction and oversight to case managers. The OCA believes the lapses in supervision may be largely due to the cadre of supervisors being stretched too far and inadequately prepared by the agency to fully assume their breadth of responsibility. A strong supervisory staff is absolutely essential to the success of the ongoing child welfare reform. An effective supervisor is not a "super worker." Supervision requires a blend of administrative, support and clinical skills.

- Reevaluate the span of control and performance measures for supervisors to permit them the time for required supervisory functions, such as field visits with case managers, regular uninterrupted conferences and review and approval of case record documentation

[33] 42 *U.S.C.* § 671 (a)(15)(A)
[34] *N.J.S.A.* 9:6-8.8 (1)(a).
[35] *N.J.S.A.* 9:6B-4 (4)(a).

including but not limited to signatory on contact sheets, case plans and family assessments.

- Thereafter, institute an accountability mechanism to assess supervisors' adherence to the established standards. As the first line of system accountability, the supervisor must be well versed in the continuous quality improvement strategies advanced by DHS.

Case Management

This audit revealed challenges in implementing the "one worker/one family" case practice model. Changes of case managers has been demonstrated to interfere with engagement and maintaining a trusting relationship with the family, contributes to delays in referring and implementing services, and impedes case planning and tracking. Worker changes also contributed to families "falling through the cracks" or cases otherwise lying dormant until they are reassigned and actively covered and "owned" by a case manager.

- Review strategies to establish and support the "one worker/one family" model statewide. Establish clear expectations and supports for stability in the workforce, including but not limited to minimizing voluntary transfers and promotions that are not essential to the conduct of business until stability at the front lines is achieved.

The audit also revealed that MVR schedules were not consistently documented in the record and minimal standards for monthly home visits were not being met. In addition, the readers noted that documented interaction with the family during these visits, when they are made, did little to address the relevant issues and move the family towards goal attainment.

- Supervisors must document the MVR schedule in the case record when assigning the case to the case manager and regularly monitor case activity to assure the MVR is being met. Establish management support systems as needed to assure supervisors have the necessary supports to fulfill this function. Supervisors should be held accountable for the requirement to accompany each case manager in the field when the caseload size and span of responsibility are determined to be manageable.

Provision of Appropriate Services

The audit revealed several issues regarding the provision of services to the family. Three families experienced the removal of their children in part because services that may have prevented the removal were not provided. Service implementation was most commonly impeded by the family's resistance or unavailability and the case manager's failure to make referrals for services. Case managers did not utilize strategies to engage families who were resistant to services. Services such as family counseling, mental health treatment, parenting skills education, and substance abuse treatment were often not provided when needed. Providing inappropriate services, delay in service implementation or failure to provide services may contribute to further deterioration of family circumstances or cases remaining open longer than necessary. Finally, the determination of the service needs of the family was in many cases based on a superficial assessment of the family.

- Under no circumstances should a child be removed from their family when the presenting problem is poverty. DHS must develop broader strategies to assist families who are confronted with homelessness, inability to pay utility bills or who struggle to provide food or medicine. Although the child welfare system and the public welfare system are both housed in DHS, their organizational lack of coordination inures to the detriment of families. DHS should ensure that staff are fully aware of available resources, offered by the state and the local community, and actively advocate on behalf of the family to secure what is needed to stabilize the family.

- Prioritize training regarding comprehensive assessment of the children, caregivers and the family as a unit. Skill building training is required in the areas of safety and risk assessment to assure that case managers understand what they are looking for and how to evaluate what they observe in the field. Skill building training is needed to assure that case managers are equipped to engage the family as appropriate in identifying its strengths and needs.

- Train, or provide refresher training as needed, for case managers and supervisors regarding intervention with involuntary, evasive and resistant families. Provide guidance regarding next steps when this barrier to service delivery cannot be overcome.

- Educate the workforce on the use of the "211 Service Directory" to identify sometimes obscure services to address the needs of the family. Assure that case managers and supervisors are aware of the full range of services available, and establish avenues to procure services that may not be readily available. Assure integrated service delivery among all agencies in DHS that provide services to children and families.

- Train the workforce regarding determination of services needs; specifically recognizing and identifying specific types of needs and how to match needs with appropriate services. Additionally, assure that case managers and supervisors are prepared to prioritize needs and provide services in a coordinated manner.

- NJ needs to commit to a statewide model of evidence based prevention services to prevent child abuse and neglect for children and youth of all ages. This effort should begin with leveraging existing resources in DHS and DHSS, including home visitation for infants and toddlers. There are currently several movements to link opportunities for prevention with early childhood age children through Abbott school family support programming and school-based youth services for adolescents in middle and high schools.

APPENDIX A – RESEARCH PROTOCOLS

Methodology

Sampling Procedures

The audit focused on 124 families (269 children) whose cases were opened between January 1, 2004 and March 31, 2004 and remained open through the date the cases were requested, June 7, 2005. The OCA obtained a list of all families whose case had been opened during the stated time frame. There were 1,241 cases referred and accepted investigation and continued service activity during the designated review period. The study encompassed a systematic 10% sample (~124 cases). The 1,241 cases were sampled as follows:

The simple random sample function in SPSS was used to randomly select exactly 154 cases (10% plus an additional over-sample of 30 cases), resulting in a sample of 154 cases, for which files were requested. Although the research plan called for reviewing 10% of the eligible cases, the 30 additional cases were drawn to replace a case if the case record was missing or unavailable. A second simple random sample of exactly 124 cases was drawn from the 154 using the simple random sample function in SPSS. This resulted in 124 cases (10% of the full sample) for review, and 30 cases that were used for replacement purposes.

During the course of the study there were thirteen occasions when a case had to be replaced because it did fit the guidelines for the audit, yet it was necessary to preserve the sample size. In that event, the study process required a selection of a case from the over-sample. If a second replacement was required, the protocols required selecting the next available case from the over-sample.

The 124 cases were reviewed by nine members of the research team. Each case was randomly assigned to one of these nine readers. The first case completed by each first reader received a second read. In addition, cases were read by a second reader if (1) the first reader requested that the case be reviewed by a second reader or (2) if the first reader disagreed with the finding of the initial report that placed the case in the sample or if s/he disagreed with the decision to remove the child(ren) from the home. Twenty-six of the 124 cases were read by a second reviewer for one of these reasons.

In the 26 cases that were reviewed by two readers, coding by the second reader was used for this study. The number of cases coded by each reviewer is presented in Table 1.

NUMBER OF CASES CODED BY EACH CASE REVIEWER (n=124)

Reviewer	# Cases Reviewed	Percent
F. Lowe	44	35.5
A. Jones	24	19.4
L. Taylor	24	19.4
P. Myers	8	6.5
M. McManus	7	5.6
M. Coogan	6	4.8
A. Bonds	5	4.0
C. Zalkind	5	4.0
K. Ryan	1	.8
Total	124	100.0

Confidentiality

The case records reviewed for this study contained personal information about the alleged child victims and their families and the alleged perpetrators. The nature of the study and the complexity of the case records prohibited the removal of identifiers from the reviewed files. Redaction of identifying information would have diminished the reviewers' capacity to assess effectively the case practice information.

Several safeguards were employed to protect the privacy of each party in each case. First, the coding sheet and database developed to manage the information extracted from each case through the file review process did not capture any personal identifiers such as name, date of birth or community of residence. Second, a unique number was assigned to each case by the research team for file tracking purposes. This number was used by case reviewers when recording case information, entering information into the database, and filing hard copies of case materials. Third, prior to accessing any of the files, all researchers and reviewers completed human subjects certification through Rutgers University and signed a confidentiality statement affirming an agreement to not disclose any identifiable information to any person not part of the research team. Fourth, all documents related to this research project were maintained in a locked facility. Only researchers and reviewers involved with this study were granted access to the room.

Definitions

Definitions and coding procedures were specified for each data element in the coding system (see Appendix C). This included using New Jersey definitions of "substantiated," "not substantiated" and "unfounded." For the data elements that required the reader to rate case practice performance, specific definitions corresponding to each coding option were provided.

Training for Readers

The nine readers selected to conduct the case reviews all have extensive prior experience in working with children and families. Three of the readers are trained in social work and seven

hold *juris doctor* degrees.[36] Five readers are staff members from the OCA. Two readers are from the Association for Children of New Jersey, and the remaining two are from Legal Services of New Jersey.

To ensure consistency in the reviews, readers attended a day-long training session facilitated by Theresa Costello, Deputy Director of ACTION and Director of the National Resource Center for Child Protective Services (NRCCPS). The training session covered the purpose and intent of every question on the coding sheet, clarified references to DYFS policies, integrated the knowledge and experience of readers to maximize consistency in interpretation of information, and established procedures to settle potential coding disagreements. In addition, a log book of common questions and concerns was maintained throughout the study to ensure consistency in coding. Finally, a staff member from the OCA served as the final authority on any questions that arose regarding coding.

Data Analysis

Research staff from the NRCCPS entered data into a database and analyzed using the Statistical Program for the Social Sciences (SPSS) software. Data analysis was further supported by Diane DePanfilis of the University of Maryland, School of Social Work. Specific analysis techniques for quantitative data included frequencies, measures of central tendency and cross-tabulations. Due to rounding, percentages reported in tables may not be exactly 100%. Staff analyzed qualitative data using standard content analysis procedures. Particular attention was paid to common themes that emerged in response to each of the questions.

[36] One reader is a trained social worker and holds a *juris doctor* degree.

APPENDIX B – SCR DATA

STATUS OF CASE (n=124)

Status of Case	Frequency	Percent
NEW	119	96.0
RE-OPEN	5	4.0
Total	124	100.0

TYPE OF COMPLAINT (n=230)[37]

Problem Types	Frequency
PHYSICAL ABUSE	35
EMOTIONAL ABUSE	2
SEXUAL ABUSE	11
NEGLECT	41
JUVENILE- FAMILY PROBLEM/CRISIS	4
DELINQUENCY	2
RUNAWAY	2
HOMELESS/HOUSING	3
DOMESTIC VIOLENCE	9
CHILD-MEDICAL	7
CHILD-EMOTIONAL	4
CHILD-PSYCHIATRIC	4
CHILD-PREGNANT	1
CHILD SUBSTANCE ABUSE	4
PARENT PSYCHIATRIC	7
PARENT- ALCOHOL ABUSE	6
PARENT- SUBSTANCE ABUSE	32
SIBLING OF CHIL REFERRED	1
FAMILY OF PERPETRATOR- OTHER EVALUATION	1
SEXUAL ASSAULT/ACTIVITIES	5
LACK OF SUPERVISION	4
PARENTING ISSUES/CONCERNS	41
ADOLESCENT PARENT	1
NEWBORN- SUBSTANCE EXPOSED	1
EVALUATION/ASSESSMENT FOR OTHER DO/ARC/IAIU	1
FOSTER HOME VIOLATION OF POLICY ASSESSMENT	1
Total	230

[37] The total number of complaints exceeds the total number of cases (124) in the sample due to more than one allegation per complaint.

SOURCE OF REFERRAL (n=124)

Source of Referral	Frequency	Percent
LEGAL	4	3.2
PARENT	16	12.9
RELATIVE	7	5.7
SCHOOL	25	20.2
SELF	3	2.4
ANONYMOUS	13	10.5
FRIEND/NEIGHBOR	4	3.2
COMMUNITY/GROUP/INDIVIDUAL	1	0.8
OTHER AGENCY	7	5.7
HEALTH	23	18.5
DYFS	3	2.4
POLICE	8	6.5
FACILITY STAFF	2	1.6
COURT	5	4.0
UNKNOWN OR MISSING	3	2.4
Total	124	100.0

NUMBER OF PERPETRATORS

Perpetrators Per Report	Frequency	Total Number of Perpetrators	Percent
0 (CHILD WELFARE CASE)	34	0	27.4
1	78	78	62.9
2	11	22	8.9
3	1	3	.8
Total	124	103	100.0

SIS HISTORY ON FAMILY CONSULTED

SIS History Consulted	Frequency	Percent
NO	18	14.5
YES	104	83.9
UNKNOWN	2	1.6
Total	124	100.0

ALLEGATIONS REPORTED TO POLICE

Reported to Police	Frequency	Percent
NO	91	73.4
YES	33	26.6
Total	124	100.0

INJURIES TO CHILD ALLEGED IN COMPLAINT

Injuries Alleged	Frequency	Percent
NO	73	58.9
YES	29	23.4
UNKNOWN	22	17.7
Total	124	100.0

INDICATION THAT CHILD NEEDED MEDICAL ATTENTION

Medical Attention Needed	Frequency	Percent
NO	95	76.6
YES	24	19.4
UNKNOWN	5	4.0
Total	124	100.0

DESIGNATED RESPONSE TIME

Response Time	Frequency	Percent
IMMEDIATE	66	53.2
24 HOURS	31	25.0
72 HOURS	14	11.3
10 DAYS	1	0.8
NONE DESIGNATED	12	9.7
Total	124	100.0

APPROPRIATENESS OF DESIGNATED RESPONSE TIME BASED ON REFERRAL

Response Time Appropriate	Frequency	Percent
NO	10	8.1
YES	102	82.2
NONE DESIGNATED	12	9.7
Total	124	100.0

APPENDIX C: DEFINITIONS

Substantiated: The available information as evaluated by the Division representative indicates that a child is an abused or neglected child as defined in N.J.A.C. 10:133-1.3 because the child has been harmed or placed at risk of harm by a parent, caregiver, temporary caregiver or institutional caregiver (N.J.A.C. 10:129A-3.3(a).

Not Substantiated: The available information, as evaluated by the Division representative provides some indication that a child was harmed or placed at risk of harm, but does not indicate that the child is an abused or neglected child as defined in N.J.A.C. 10:133-1.3 (N.J.A.C. 10:129A3.3(a).

Unfounded: Either i. there is no evidence of conduct that would pose risk to the child; ii. there is no evidence that a parent, caregiver, temporary caregiver, or institutional caregiver or child was involved; or iii. the available information indicates that the actions of the parent, caregiver, temporary caregiver, or institutional caregiver were necessary and reasonable and the incident was an accident (N.J.A.C. 10:129A-3.3(a)).

Table 20- Engagement with Child

Good engagement efforts: Numerous attempts/varied approaches/age appropriate/timely response.
Fair engagement efforts: Two or more attempts/ sometimes age appropriate/somewhat timely response.
Marginal engagement efforts: More than one attempt but not age appropriate or not timely.
Poor engagement efforts: One attempt.
No engagement efforts: No attempts to engage child.

Tables 21 & 22 Engagement with Primary and Secondary Caregivers

Good engagement efforts: Numerous attempts/varied approaches/culturally appropriate/timely response.
Fair engagement efforts: Two or more attempts/somewhat varied approaches/somewhat culturally appropriate/somewhat timely.
Marginal engagement efforts: More than one attempt/not varied approach/not culturally appropriate/or not timely.
Poor engagement efforts: One attempt.
No engagement efforts: No attempts to engage caregiver.

Table 27- Practice Performance: Planning for Change

Good planning: Individualized and relevant to the family; family fully participated.
Fair planning: process reflected some family involvement in planning; some individualization/relevance.
Marginal planning: Process not family-oriented – directed at only primary caregiver or only the child.
Poor planning: Planning process was not engaging but rather driven by worker and resulted in routine case plan.
Absent or misdirect planning: No planning with the family.